STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING 00		X3) DATE SURVEY COMPLETED	
	155165	B. WING		12/18/2012	
	PROVIDER OR SUPPLIER EW VILLAGE	586 EA	ADDRESS, CITY, STATE, ZIP CODE STERN BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F0000	This visit was for Recertification and State Licensure Survey. This was in conjunction with the Investigation of Complaint #IN00121184. Survey dates: December 11, 12, 13, 14, 17 and 18, 2012 Facility number: 000082 Provider number: 155165 AIM number: 100289640 Survey Team: Jill Ross, RN, TC Diana Sidell, RN Gloria Reisert, MSW Census bed type: SNF/NF: 108 Total: 108 Census payor type: Medicare: 19 Medicaid: 69 Other: 20 Total: 108 Supplemental sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth the statement of deficiencies. This plan of correction is prepared and submitted becator of requirement under state and federal law. Please accept this plan of correction as our crediallegation of compliance. Please find enclosed the plan of correction for the survey ending December 18, 2012. Due to low scope and severity of the survey finding, please find sufficient documentation providing evidence of compliation with the plan of correction. The documentation serves to confit the facility's allegation of compliance. Thus, the facility respectfully requests the grant of paper compliance. THe fact additionally requests paper resumplementation be necessary to confirm said compliance, feel to contact me.	e on use d sible ase ng the irm ting ility view nal	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155165	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 8/2012
	PROVIDER OR SUPPLIER	586 EA	ADDRESS, CITY, STATE, ZIP CO STERN BLVD SVILLE, IN 47129	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Quality Review completed on January 3, 2013 by Cheryl Fielden RN.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155165	A. BUI			12/18/	2012
			B. WIN		A DDDDGG CYTY CTATE GIR CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
D.) (ED) (I					STERN BLVD		
RIVERVII	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
F0156	483.10(b)(5) - (10	0), 483.10(b)(1)					
SS=A	NOTICE OF RIG	HTS, RULES, SERVICES,					
	CHARGES						
	The facility must inform the resident both						
	orally and in writing	ng in a language that the					
		ands of his or her rights and					
		llations governing resident					
		onsibilities during the stay					
	•	e facility must also provide					
		the notice (if any) of the					
	•	under §1919(e)(6) of the					
		ation must be made prior to					
		n and during the resident's					
	stay. Receipt of such information, and any amendments to it, must be acknowledged in						
		i, must be acknowledged in					
	writing.						
	The facility must i	inform each resident who is					
	•	aid benefits, in writing, at					
		sion to the nursing facility					
		dent becomes eligible for					
		ems and services that are					
		ng facility services under the					
		r which the resident may					
	not be charged; t	hose other items and					
	services that the	facility offers and for which					
	the resident may	be charged, and the					
	amount of charge	es for those services; and					
		lent when changes are					
		s and services specified in					
	paragraphs (5)(i)	(A) and (B) of this section.					
		inform each resident					
		time of admission, and					
	•	g the resident's stay, of					
		e in the facility and of					
		e services, including any					
	•	ces not covered under ne facility's per diem rate.					
	iviculcate of by th	ie iacility s per uletti tate.					
	The facility must	furnish a written description					
	of legal rights whi						
	or logar riginto Will						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIM DDIG	00	COMPLETED
		155165	A. BUILDING		12/18/2012
			B. WING	ADDRESS CITY STATE ZID CODE	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
חוייבטייו				STERN BLVD	
RIVERVI	EW VILLAGE		CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		he manner of protecting under paragraph (c) of this			
	procedures for e Medicaid, includi assessment und determines the e non-exempt resc institutionalizatio community spou- resources which available for pay institutionalized s	the requirements and stablishing eligibility for ng the right to request an er section 1924(c) which extent of a couple's curces at the time of an and attributes to the se an equitable share of cannot be considered ment toward the cost of the spouse's medical care in his f spending down to ty levels.			
	telephone number client advocacy (survey and certificensure office, program, the program, the program, and the and a statement complaint with the certification ager abuse, neglect, a resident property	les, addresses, and ers of all pertinent State groups such as the State ication agency, the State the State ombudsman tection and advocacy Medicaid fraud control unit; that the resident may file a e State survey and acy concerning resident and misappropriation of in the facility, and with the advance directives			
	489 of this chapt written policies a advance directive include provision written informatic concerning the ri	comply with the ecified in subpart I of part er related to maintaining nd procedures regarding es. These requirements s to inform and provide on to all adult residents ght to accept or refuse cal treatment and, at the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155165	B. WING			12/18/	/2012
NAME OF I	PROVIDER OR SUPPLIEF	.	•		ADDRESS, CITY, STATE, ZIP CODE	•	
RIVFRVI	EW VILLAGE				STERN BLVD SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	I		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	directive. This in of the facility's positive advance directive. The facility must name, specialty, physician responsorm. The facility written information and written information and use Mediand how to receip payments covered and how to receip payments covered and the second and the second and the second and the second affected and were stopped. The stopped affected 1 of 3 medicare Liability and Application and the second and the stopped and second affected and second and second affected and second and second affected and second and secon	acility failed to ensure issued "Notice of when therapy was Medicare benefits This deficient practice residents reviewed for lity and Appeal dent #2) es: 1 2:45 p.m, a request ne Business Office withe Medicare opeal Notices issued to	F01:	56	F156 States that the facility m inform the resident both orally and in writing in a language the the resident understands of his her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. facility must also provide the resident with the notice (if any the State developed under §1919(e)(6) of the Act. Such notification must be made pricor upon admission and during resident's stay. Receipt of sucinformation, and any amendments to it, must be acknowledged in writing. The facility must inform each resid who is entitled to Medicaid benefits, in writing, at the time admission to the nursing facilitor, when the resident become eligible for Medicaid of the iter and services that are included nursing facility services under	at s or t t The or to the ch ent e of ty s ms	01/19/2013

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/18/2012
	ROVIDER OR SUPPLIER	.	STREET.	ADDRESS, CITY, STATE, ZIP CODI ASTERN BLVD (SVILLE, IN 47129	E
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	DATE COMPLETION DATE
	supposed to be everyone. Since didn't exhauste	e didn't know we were e issuing the letters to be she went home and ed her benefits, we er signed before she		State plan and for which the resident may not be charged those other items and send that the facility offers and which the resident may be charged, and the amount charges for those services inform each resident when changes are made to the and services specified in paragraphs (5)(i)(A) and (this section. The facility may inform each resident before the time of admission, and periodically during the resident stay, of services available facility and of charges for services, including any charges for services, including any charges for services not covered undedicare or by the facility diem rate. The facility must a written description of legrights which includes: And description of the manner protecting personal funds paragraph (c) of this section description of the requirer and procedures for estable eligibility for Medicaid, incompart to request an assessment under section 1924(c) which determines extent of a couple's noneresources at the time of institutionalization and attored to the community spouse equitable share of resources available for payment tow cost of the institutionalized spouse's medical care in the process of spending of the process of the process of spending of the process of the process of the proce	ged; vices for e of s; and n items B) of ust re, or at d ident's in the those larges inder 's per it furnish gal of , under on; A ments ishing luding n is the exempt ributes an ces eed ard the d his or

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 12/18/2012	
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE STERN BLVD (SVILLE, IN 47129	
	EW VILLAGE SUMMARY S' (EACH DEFICIEN		586 EA	STERN BLVD	and cy vey State with tion ance part rding ns nts t or
				directive. This includes a writ description of the facility's pol to implement advance directive and applicable State law. The facility must inform each resid of the name, specialty, and we contacting the physician responsible for his or her care. The facility must promine display in the facility written	icies ves dent ay of
				alopidy in the lacility written	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPLE 12/18/2	ETED	
	PROVIDER OR SUPPLIER		STREET .	ADDRESS, CITY, STATE, ZIP CODE ASTERN BLVD (SVILLE, IN 47129	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
				information, and provide to residents and applicants for admission oral and written information about how to ap and use Medicare and Medibenefits, and how to receive refunds for previous paymer covered by such benefits. The facility will ensure this requirement is met through following corrective measure. Resident #2 was issued the Notice of Medicare Non-Coverage. All Medicare residents have the potential affected. All Medicare reside will be audited by the Administrator or designee to ensure that all required Notime Medicare Non-Coverage Non-Coverage Non-Coverage Non-Coverage Non-Coverage Non-Coverage Non-Coverage will be issued the Notice of Medicare Non-Coverage Within 48 hours. In the discharging from the facility being removed from Medicare who are either discharging home or who are being removed from Medicare Non-Coverage Non-Coverage Non-Coverage Non-Coverage Non-Coverage Non-Coverage Notice is ser within 48 hours. In the ever a resident discharges unexpectedly, before the notican be issued, then the noticattempt to be issued via certain the signer of the notican be issued via certain the notical tempt to be issued via certain the signer of the notical tempt to be issued via certain the notical tempt to be issued via certain the signer of the notical tempt to be issued via certain the notical tempt to be issued via certain the notical tempt to be issued via certain the signer of the notical tempt to be issued via certain the notical tempt to a notical temp	ply for icaid ships the ships the ships to be lents or ce of or dicare the ships the s	

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Event ID: N5L711

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155165	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/18/2012
	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE STERN BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION DATE
				mail.Business Office Staff win-serviced on or before Jan 17 th by the Administrator (shiften Attachment 156-3) on the Clust for Issuing a Notice of Medicare Non-Coverage No (see Attachment 156-1). 4. Business Office Manager or designee will utilize the Continuous Quality Improver Notice of Medicare Non-Coverage Letter tool (shiften Attachment 156-2) to ensure all Medicare residents receivally appropriate notice of non-coverage letter as appropriate weekly for 4 westhen monthly for 6 months, the quarterly thereafter. These will be reviewed during the facility's quarterly CQI meeting and the plan of action adjust accordingly. If a threshold of is not met, the plan of action be adjusted accordingly by the CQI committee. 5. The abordorrective measures will be completed on or before January 17 th, 2013.	uary ee neck tice The ment ee that ve the eks, hen audits ngs ed f 95% will he ve

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155165	A. BUILDING B. WING		12/18/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			STERN BLVD	
BI//ED//II	EW VILLAGE			SVILLE, IN 47129	
	LVV VILLAGE		CLAIN		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0157	483.10(b)(11)				
SS=D	NOTIFY OF CHA				
	(INJURY/DECLIN				
	,	mediately inform the			
		with the resident's			
		known, notify the resident's ve or an interested family			
		ere is an accident involving			
		h results in injury and has			
		equiring physician			
	· ·	gnificant change in the			
		al, mental, or psychosocial			
	status (i.e., a dete	erioration in health, mental,			
	or psychosocial s				
	threatening condi	tions or clinical			
		need to alter treatment			
		a need to discontinue an			
	•	eatment due to adverse			
	•	r to commence a new form			
		a decision to transfer or ident from the facility as			
	specified in §483.				
	opcomed in 3 loo	. 12(a).			
	The facility must	also promptly notify the			
		nown, the resident's legal			
		interested family member			
	when there is a c	hange in room or			
	roommate assign	ment as specified in			
		a change in resident rights			
		State law or regulations as			
	specified in parag	graph (b)(1) of this section.			
	Th - f '''	and and and a single U			
		record and periodically			
		ss and phone number of al representative or			
	interested family	·			
	microsicu iaiilliy	member.	F0157	E157 Doquiros that a facility	01/19/2013
	Dood or rese	rd rovious and into	1.012/	F157 Requires that a facility must immediately inform the	01/19/2013
		rd review and interview		resident; consult with the	
	the facility faile	_		resident's physician; and if	
		the family when there		known, notify the resident's le	gal
	was a significa	nt change of Resident		representative or an interested	
	-				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLE	TED
		155165	A. BUI B. WIN			12/18/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	STERN BLVD		
חו/בט/ו							
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#108's condition	on. This affected 1 out			family member when there is a		
	of 6 residents i	reviewed for accidents			accident involving the resident		
	and hospitaliza	ations.			which results in injury and has		
					potential for requiring physicia		
	Findings includ	1 0.			intervention; a significant chan in the resident's physical, men	-	
		ie.			or psychosocial status (i.e., a	lai,	
	December :	f Di-l			deterioration in health, mental,	or	
		for Resident #108 was			psychosocial status in either li		
		/12 at 3:05 p.m. This			threatening conditions or clinic		
	resident was a	dmitted on 8/3/12 and			complications); a need to alter		
	then readmitte	d on 9/27/12 after she			treatment significantly (i.e., a		
	had been hosp	oitalized on 9/24/12.			need to discontinue an existing	9	
		included but were not			form of treatment due to adver		
	_	phageal reflux, anxiety,			consequences, or to commend	ce a	
	-	ctive lung disease			new form of treatment); or a		
		•			decision to transfer or discharg		
	(COPD), anem	nia, and depression.			the resident from the facility as specified in §483.12(a). The	·	
					facility must also promptly noti	fv	
	_	s were received			the resident and, if known, the	-	
	12/17/12 at 2:4	10 p.m., from the			resident's legal representative		
	Medical Recor	ds Designee. This			interested family member whe		
	resident was s	een on 9/17/12 by			there is a change in room or		
	psychiatric ser	vices. A note dated			roommate assignment as		
	1 ' '	, "Resident remains			specified in §483.15(e)(2); or		
	· ·	ited" There were no			change in resident rights unde	r	
	•	of this resident being			Federal or State law or regulations as specified in		
	l •	•			paragraph (b)(1) of this		
		n 9/20/12 a note			section. The facility must record	, l	
		dent was noted twice			and periodically update the	-	
	during this shif	t to enter another			address and phone number of	the	
	resident's roon	n without permission"			resident's legal representative		
	On 9/21/12 the	e note indicated no			interested family member.The		
	signs or symptoms of confusion at 2:06 a.m. At 3:12 p.m., on 9/21/12				facility will ensure this		
					requirement is met through the		
		d, "Is still confused			following corrective measures:		
		30 p.m. on 9/21/12 the			Resident #108 current condition		
	_	•			has been reviewed by and IDT		
		.Resident continues to			team and communicated to		
	be confused a	nd rambles			physician and family.2. All		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	LDING	00	COMPLE	ETED
		155165	A. BUII B. WIN			12/18/2	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8			STERN BLVD		
RI\/ER\/II	EW VILLAGE				SVILLE, IN 47129		
			1				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	incoherently."				residents with a recent change		
					condition have the potential to	be	
	On 9/22/12 at 2	2:49 a.m., the note			affected. Any resident with a recent significant change in		
	indicated resid	ent continued to be			condition will be audited, by D	NS	
	confused. On	9/22/12 at 12:55 p.m.,			or Designee, to ensure that the		
		I, "Resident remains			physician and family have bee		
		ost xs (times) and			notified. 3. The charge nurse		
		, ,			who identifies the change in		
	_	hift. On 9/23/12 at			condition will contact the		
	12:01 p.m., the				resident's physician and family		
		oted" On 9/24/12 at			communicate the change. The		
	12:12 p.m. the	note indicated resident			charge nurse will document th		
	had been "mor	e disorientated". A			nurses' actions/interventions in the nurses' notes and will add		
	note on 9/24/1	2 at 4:55 p.m. stated,			the daily charting. The DNS, of		
	"Resident conf	used with paranoia			designee, will review	"	
		g wheelchair around			documentation to ensure		
		t O 2 onMini neb			physician and family are notific	ed .	
	_				If family and physician are not		
	,	tment) given with O 2			notified, appropriate action will	be	
	-	o 90%" They			taken. Nursing will be in-servi		
		der to send the resident			on Resident Change of Condit		
	•	and family was notified			Policy and Procedure by the D	ons	
	at this time.				and Staff Development		
					Coordinator on or before Janu 17 th, 2013 (see Attachment A	,	
	In reviewing th	e record there was no			4. The DNS or designee will	٠٫٠	
	_	de to the physician of			utilize the Continuous Quality		
		her condition with the			Improvement Change of		
	_	9/24/12 at 4:55 p.m.,			Condition tool (see Attachmen	t	
		d been confusion for			157-1) to ensure that physicial		
					family, and responsible party a		
	many days prid	JI TO THIS OHE.			notified timely about changes i	in	
					resident's condition. The	ont	
		care plan dated 8/16/12			Continuous Quality Improvement Change of Condition tool will be		
	on 12/17/12 at 10:40 a.m., from				utilized to ensure compliance i		
	Medical Recor	ds Designee, stated,			being met weekly for 4 weeks,		
	"resident also	o has respiratory			then monthly for 6 months, the		
	problems whic	•			quarterly thereafter. These au		
	•	ctor to cognitive ability			will be reviewed during the		
		otor to cognitive ability			<u> </u>		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155165	A. BUILDING B. WING		12/18/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		ASTERN BLVD	
RIVERVI	EW VILLAGE		CLAR	(SVILLE, IN 47129	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	at times"			facility's quarterly CQI meeting	
				. If a threshold of 95% is not r	· · · · · · · · · · · · · · · · · · ·
	Interview with	the Medical Records		the plan of action will be adjus	sted
		2/17/12 at 10:40 a.m.,		accordingly by the CQI	
	•			committee. 5. The above	
		this resident did not		corrective measures will be	n/
		en on as directed and		completed on or before Janua 17 th, 2013.	ı y
		n times when her		17 11, 2013.	
	oxygen levels	went down.			
	Interview with	the Unit Manager for			
	2nd floor on 12	2/17/12 at 11:00 a.m.,			
	she indicated t	this resident was doing			
		ow that she keeps her			
		ter. There should			
	1	fication to the doctor of			
	a change in co	ondition.			
	2.1.5(0)(2)				
	3.1-5(a)(2)				
					1

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Event ID: N5L711

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	, 00		COMPLETED	
		155165	B. WING		12/1	8/2012	
NAME OF I	PROVIDER OR SUPPLIE	D	STR	EET ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	FROVIDER OR SUFFLIE	K	586	6 EASTERN BLVD			
RIVERVI	EW VILLAGE		CL	ARKSVILLE, IN 47129			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPR		COMPLETION	
		R LSC IDENTIFYING INFORMATION)	TAC	j DEFICIENCY)		DATE	
F0250 SS=D	483.15(g)(1) PROVISION OF SOCIAL SERVICE The facility must social services to highest practicate psychosocial we Based on recogniterview, the medically related resident when changed from rehabilitation to the nursing house to non-con (Resident #81 resident in obtoin discharge (Resident pract residents who social services) Findings included the social services are sident in obtoin services are indicated admitted on 9/diagnoses whith not limited to sobstruction - context exacerbation; agoraphobia were social services are sidents.	provide medically-related attain or maintain the ble physical, mental, and ll-being of each resident. ord review and facility failed to provide ted social services to a the discharge plan going home after o needing to remain in the for long term care impliance with therapy hand failed to assist a aining services upon sident #159). This ice affected 2 of 2 were reviewed for a for discharge planning. de: ne clinical record for on 12/17/12 at 10:09 the resident was (21/12 and had ich included, but were Chronic airway	F0250	F250 States that the facility provide medically-related services to attain or mainthighest practicable physicomental, and psychosocial well-being of each resider facility will ensure this requirement is met throug following corrective measures Resident #81 care plan updated to reflect the resident #159 care plan updated to address the redischarge goals and need Resident #159 has since discharged home. 2. All residents who have the goal discharge home have the potential to be affected. A resident's that have a goal discharge home will be auby the DNS or designee, the ensure appropriate care pland interventions are in planditionally, all residents admitted with the goal to discharge home but are sidently for an extended of time, will be audited by designee to assure care phave been updated .3. So Services Director will com	social ain the ail, t.The t.The the res:1. vas lent's vas sident's s. al to li to dited, o ans ace. vho aying in period DNS or ans cial	01/19/2013	
		pain, schizophrenia		the Discharge to Home Cl List (see Attachment 250-			

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Event ID: N5L711

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00			COMPLETED	
		155165				12/18/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
DI) (ED) (I	E)4/) /// 1 4 0 E				STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
					IDT will review the form to ens	ure	
	A Social Service	ce note dated 9/26/12			all arrangements are met. Any	,	
		dicated: "Resident			resident who is designated to		
					discharge to home and, it is		
	plans to live with [name of family				identified that they are unable	to	
	member] upon d/c from facility" Review of the 9/28/12 Admission				do so, the care plan will be		
					updated by the IDT to ensure proper plans are in place. Soc	ial	
					Services will be in-serviced on		
	MDS [Minimum Data Set]				Resident Discharge to Home		
	Assessment:"	Resident expects to be			Policy by the DNS and		
	discharged to the community". The				Administrator on or before		
	9/28/12 Admission MDS Assessment				January 17 th , 2013 (see		
		the resident scored a			Attachment 250-2). 4. Social		
					Services will utilize the Discha	rge	
	_	ecall and orientation			to Home checklist (see		
		nt was alert and			Attachment 250-1) to ensure the	hat	
	oriented x 4 pe	er nursing notes.			all appropriate services have	L _	
					been arranged for residents w	no	
	On 10/8/12, [na	ame of agency]			are discharging home. Additionally, the Social Service	20	
	evaluator visite	ed the resident where			Director or designee will utilize		
	she also indica	ited to him that she			the Continuous Quality	•	
		on only a short term			Improvement Discharge		
		and would discharging			Planning/Discharge to Home t	ool	
	1				(see Attachment 250-3) to ens	ure	
	to home to live	with family.			residents' discharge plans and	I	
					services are appropriate week	ly	
		ce note dated 11/1/12			for 4 weeks, then monthly for 6		
	at 2:27 p.m. in	dicated - "spoke with			months, then quarterly thereaf	ter.	
	resident at leng	gth regarding some			These audits will be reviewed	01	
	concerns she i	s experiencing. She			during the facility's quarterly C		
	stated that she				meetings and the plan of actio adjusted accordingly. These	11	
		[name of facilities]. She			audits will be reviewed during	the	
		der the care of therapist			facility's quarterly CQI		
	1	-			meetings. If a threshold of 95%	√ is	
	-	cy]. The resident			not met, the plan of action will		
		I speak with her			adjusted accordingly by the Co		
	therapist about	t her d/c plans and any			committee. 5. The above		
	other concerns	Res [Resident] has			corrective measures will be		
	an apartment t	hat is in her name, but			completed on or before Janua	ry	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165			(X2) MULTIPLE CONSTRUCTION A. BUILDING D. NING		(X3) DATE SURVEY COMPLETED 12/18/2012	
	PROVIDER OR SUPPLIEF		586 EA	ADDRESS, CITY, STATE, ZIP CODE ASTERN BLVD KSVILLE, IN 47129	1 1 1 1 2 1 2 1 2	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION		
TAG		n] was living there	TAG	17 th , 2013.	DATE	
	now. She does the apt for reas issuesWill f/ resident for en- motivation and concerns or pro-	s not want to go back to sons of it having mold u [follow up] with couragement, any new or existing oblems."		17 di, 2010.		
		abursement indicated puld no longer be 12/21/12.				
	indicated the re	urse Practitioner note esident stated to her leted rehab and wants on.				
	at 3:17 p.m., in writer to discuss that she wants couple of week assisted living assured reside would be coord departure. Will up] with d/c pla	ce note dated 11/27/12 ndicated - "Res came to ss d/c plans. She stated to leave the facility in a as and has secured an apartment. Writer ent that all d/c planning dinated before her continue to f/u[follow anning prn [as urther notes could be				
	on 12/12/12 at indicated she w	rview with the resident 10:00 a.m., she was going to be m the facility on				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMP			
		155165	B. WIN	IG		12/18/2	2012
NAME OF P	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
					STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION DATE
IAG	12/21/12.	R LSC IDENTIFYING INFORMATION)		IAG	DEI ICIERCI)		DATE
1	12/21/12.						
	A second inter	view with the resident					
	on 12/17/12 at 1:30 p.m., indicated she was planning on going to a new apartment situation on 12/20/12 and						
	that all arrangements and consents had been developed and set-up by						
	the facility Social Worker, MD and a case worker from an outside agency.						
	Case Worker III	om an eaterae agency.					
	During an interview with Social						
		12/17/12 at 1:35 p.m.,					
		she knew the resident					
		ne around the 22nd of					
		t the resident set up her					
	· ·	She indicated she					
	should have do	ocumented what the					
	plans were after	er talking to the					
	resident to see	e if there was anything					
	else she could	do for the resident.					
	At 3:30 p.m., S	Social Worker #1					
	indicated that t	the resident was very					
	confused today	y and did not know					
	what she was	talking about as the					
	information she	e gave was inaccurate					
		esident was going back					
		e mold problem was					
		and she was actually on					
	a waiting list fo	or the apartments she					
	wants.						
		ne clinical record for					
	Resident #81 o	on 12/13/12 at 4:31					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155165	B. WIN			12/18/	2012
NAME OF B	DROVIDED OD GUDDUIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C		586 EAS	STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		the resident was					
	admitted to the facility on 10/4/12 and had diagnoses which included, but						
		d to: senile dementia,					
	1 -	order with depressed					
	mood, and generalized anxiety disorder Review of Social Worker #1's note						
		2 indicated :"res					
	[resident] d/c plans are to go home upon completion of therapy."						
		on or incrupy.					
	A Social Worke	er #1's note dated					
	11/01/12 at 3:1	l1 p.m., indicated					
	"Spoke with re	sident and son about					
	d/c planning ar	nd her current course of					
	therapy. Res s	tated that before her					
	admission, she	e independently					
	cooked, cleane	ed, bathed, toileted,					
	and walked. SI	ne expressed desire to					
	do all of the ab	ove before d/c. Writer					
	encouraged re	s to attend therapy					
	sessions to me	eet her short term goal					
	Will continue to	o encourage, motivate					
	and assess for	any changes or					
	concerns.	-					
		#1's note dated					
		a.m., indicated "Set					
		h resident's son					
		non-compliance issues					
	with therapy. T						
	Services and E	ED [Executive Director]					
	will attend."						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/18/2012
	PROVIDER OR SUPPLIE	R	586 EA	ADDRESS, CITY, STATE, ZIP CODE ASTERN BLVD ASVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the resident's therapy and dicould be located A 10/25/12 PT note indicated max encourage with Physical refused therapimportance of has progresse goal but is not transfers or ship progress with OT [Occupation Therapist Progress with location and technologies and technologies and technologies and technologies and technologies and technologies and 11/9/12 -" The	[Physical Therapy] : "Pt [patient] needs ement to participate Therapy and frequently by, even after therapy explained. Pt d with strengthening progressing with owing consistent gait" In all Therapist] gress and Discharge 1/12 - "The patient did ifficant progress towards and to adjust treatment aniques to encourage pt Patient with			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE : COMPL		
		155165	A. BUI B. WIN	LDING IG		12/18/	
N. 1. 2	AD OLUBER OF STATE		D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1.10		ompliance with Speech					J.112
	_	Plan of care]. Patient					
		with most Speech					
		tasks; decreased					
	motivation to p	articipate."					
	Dhysiaal Thair-	niat Drogress and					
		pist Progress and nmary: 11/1/12 -					
	_	tion to participate in					
		om Physical Therapy					
services secondary patient reached maximum benefits from therapy at							
	this time."						
	During an inter	view with Social					
	_	12/17/12 at 3:20 p.m.,					
		the resident was given					
	a break from th	erapy after d/c in					
		ovember in hopes that					
		would feel more					
		k with her all the time					
	_	nd motivate her. I don't en't documented on					
		lovember note. The					
		of what was going on					
		eement with putting					
		d for a month. He					
		uilding an addition on					
		er but she has to be					
		ain things before she					
		me. I think therapy has k up again and is					
	•	seen again so she can					
	get stronger to	_					
	_						

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Event ID: N5L711

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PRINTED: 01/22/2013 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155165	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPL 12/18/	ETED
	PROVIDER OR SUPPLIER EW VILLAGE	586 EA	ADDRESS, CITY, STATE, ZIP CO STERN BLVD SVILLE, IN 47129	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	During an interview with the Speech Therapist and the Occupational Therapy Assistant on 12/17/12 at 3:25 p.m., they indicated the resident had not been picked back up again for therapy. 3.1-34(g)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155165	B. WING		12/18/2012
	PROVIDER OR SUPPLIE	R	586 E	r address, city, state, zip code ASTERN BLVD KSVILLE, IN 47129	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	DROWDENG N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0272 SS=D	The facility must periodically a co standardized repeach resident's for a facility must massessment of a resident assess specified by the must include at I Identification and Customary routin Cognitive pattern Communication; Vision; Mood and behave Physical function problems; Continence; Disease diagnost Dental and nutrit Skin conditions; Activity pursuit; Medications; Special treatmer Discharge potent Documentation or regarding the adperformed on the the completion of (MDS); and	vior patterns; ell-being; ning and structural sis and health conditions; tional status; hts and procedures;	E0272	T272 States that the facility m	01/10/2012
	interview the f an assessmer	record review and acility failed to conduct nt on Resident #108 s a significant change in	F0272	F272 States that the facility m conduct initially and periodical comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility	ly a

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
		155165	1		- ,	12/18/	2012
		1.23.20	B. WIN		ADDRESS COMPANY TO THE PARTY OF	,	· -
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					STERN BLVD		
RIVERVI	EW VILLAGE			CLARKSVILLE, IN 47129			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	her condition.	The affected 1 out of 2			must make a comprehensive		
	residents revie	ewed for significant			assessment of a resident's		
		sments. (Resident			needs, using the resident		
	#108)				assessment instrument (RAI)		
	#100)				specified by the State. The		
					assessment must include at le		
	B. Based on r	ecord review and			the following:Identification and	מ	
	interview, the	facility failed to initiate			demographic		
		ment and ensure the			information;Customary		
		skin assessment when			routine;Cognitive patterns;Communication;Visio	n:M	
	1				ood and behavior) II, IVI	
	the resident developed a rash on 2				patterns;Psychosocial		
	1	sions. This deficient			well-being;Physical functionin	a	
	practice affect	ed 1 of 2 residents			and structural	9	
	reviewed for s	kin impairments.			problems;Continence;Disease	7	
	(Resident #15	2)			diagnosis and health		
	`	•			conditions;Dental and nutrition	nal	
	Findings include	do:			status;Skin conditions;Activity		
		uc.			pursuit;Medications;Special		
	l. <u> </u>				treatments and		
		iew for Resident #108			procedures;Discharge		
	was done on 1	2/13/12 at 3:05 p.m.			potential;Documentation of		
	This resident w	vas admitted on 8/3/12			summary information regardir	ng	
	and then read	mitted on 9/27/12 after			the additional assessment		
		hospitalized on			performed on the care areas		
		diagnoses included but			triggered by the completion of	the	
		~			Minimum Data Set (MDS);		
		ed to: esophageal reflux,			andDocumentation of	. .	
	-	ic obstructive lung			participation in assessment.T	ne	
	disease (COP	D), anemia, and			facility will ensure this	0	
	depression.				requirement is met through th following corrective measures		
	'				Resident #152's skin assessn		
	Progress notes	s were received			was completed . Resident #		
	_				significant change assessmen		
		40 p.m., from the			was completed. 2. All reside		
		ds Designee. This			who have had a recent or		
	resident was s	een on 9/17/12 by			significant change in condition	n will	
	psychiatric ser	vices. A note dated			be audited, by DNS or Design		
	1 ' '	, "Resident remains			to ensure that an assessment		
		ated" There were no			been initiated/completed. All		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00 COMP		COMPL	ETED
		155165				12/18/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹			STERN BLVD		
DI\/ED\/I	EW VILLAGE				SVILLE, IN 47129		
RIVERVI	EW VILLAGE			CLARK	3VILLE, IN 47 129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	previous notes	of this resident being			resident's that have a recent s	skin	
	disoriented. O	n 9/20/12 a note			integrity impairment will be	4-	
	stated, "Resident was noted twice				audited, by DNS or Designee ensure an appropriate skin	ιο	
	during this shif	t to enter another			assessment has been		
	_	n without permission"			completed. 3. The charge nu	ırse	
	On 9/21/12 the note indicated no				who identifies the change in		
	signs or symptoms of confusion at				condition will contact the		
	2:06 a.m. At 3:12 p.m., on 9/21/12				resident's physician and famil		
		-			communicate the change. Th		
	the note stated, "Is still confused				charge nurse will document th	ie	
	today" At 10:30 p.m., on 9/21/12 the				nurses assessment/ actions/interventions in the		
	note stated, "Resident continues to				nurses' notes and will add to	lailv	
	be confused and rambles				charting. The DNS or Design	•	
	incoherently."				will review documentation to		
					ensure physician and family a	re	
	On 9/22/12 at :	2:49 a.m., the note			notified and assessment is		
	indicated resid	ent continued to be			completed . If the assessmer		
	confused. On	9/22/12 at 12:55 p.m.,			not completed appropriate act	ion	
		I, "Resident remains			will be taken. Residents who develop a rash, or recent skin		
		ost xs (times) and			integrity event, will have a skill		
		hift. On 9/23/12 at			assessment completed by the		
	12:01 p.m., the				charge nurse immediately upo		
	i i	oted" On 9/24/12 at			notification. The DNS or		
					Designee will review skin		
		e note indicated			assessments to ensure the		
	resident had be				assessments are completed		
		A note on 9/24/12 at			accurately and completely. Nursing will be		
		ed, "Resident confused			in-serviced on the Skin		
	with paranoia r	noted. Pushing			Management Program Policy		
	wheelchair aro	und nursing without O			(see Attachment A) and the		
	2 onMini neb	(breathing treatment)			Change of Condition Policy by	the	
	given with O 2	saturation up to			DNS and Staff Development		
	~	received an order to			Coordinator, on or before Jan		
	1	ent to the hospital and			17 th , 2013. 4. The DNS of	or	
		ified at this time.			designee will utilize the Continuous Quality Improvem	ent	
	laining was not	mod at tino timo.			Skin Management Program to		
	In reviewing th	o record there was as			(see Attachment 272-1) to en		
	in reviewing th	e record there was no			(555 / 11.6511115111 272 1) 10 0111		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	COMPLETED	
		155165	B. WIN			12/18/2012
NAME OF F	DDOMDED OF CLIDE IE	D.			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	K		586 EA	STERN BLVD	
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ide to the physician of			that any residents with a skin integrity impairment has an	
	_	her condition with the			appropriate assessment	
		9/24/12 at 4:55 p.m.,			completed. Additionally, the D	ONS
		d been confusion for			or designee will utilize the	
	many days prior to this one. Review of the care plan dated 8/16/12 on 12/17/12 at 10:40 a.m., from Medical Records Designee, stated, "resident also has respiratory problems which could be a contributing factor to cognitive ability				Continuous Quality Improvem	ent
					Change of Condition tool(see	, no. (
					Attachment 272-2) to ensure a residents who has experience	· .
					significant change has a	~
					significant change assessmen	t
					completed as appropriate wee	-
					for 4 weeks, then monthly for	
					months, then quarterly thereat These audits will be reviewed	
	at times"				during the facility's quarterly C	
					meetings If a threshold of 9	
	There were no	assessments found for			is not met, the plan of action w	/ill
	this significant	change in Resident			be adjusted accordingly by the	
	#108's record.	•			CQI committee. 5. The above	9
					corrective measures will be completed on or before Janua	n/
	Interview with	the Medical Records			17 th , 2013.	'y
		2/17/12 at 10:40 a.m.,			,	
	_	there was not an				
		ound for this resident for				
	this time perio					
	i -	the clinical record for				
	5	on 12/13/12 at 4:31				
		I the resident was				
	•	e facility on 10/4/12 and				
		s which included, but				
	_	ed to: cellulitis/abscess				
	1 -	tatic neoplasm bone				
	and brain.					
	MD progress r	notes indicated that on				
		Nurse Practitioner [NP]				
		ent due to a rash which				

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Event ID: N5L711

Facility ID: 000082

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTIO		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155165	A. BUI. B. WIN			12/18/	2012
		<u> </u>	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			STERN BLVD		
RI\/ER\/I	EW VILLAGE				SVILLE, IN 47129		
					OVILLE, IIV 47 123		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	was a red rash	to the entire body					
	which had star	ted that day - the					
	diagnosis the I	NP gave was					
	"Dermatitis".						
	Review of the nursing notes between 11/13/12 and 11/20/12 indicated the resident had developed a rash with occasional itch. Review of the November 2012 Physician Orders indicated a new						
		eived on 11/13/12 for					
	•	gy 25 mg [milligrams]					
		QID [4 times a day] but					
		that day thru 11/16/12					
	to PRN [as nee	eded].					
	On 11/15/2012	2 through 11/20/12, the					
	resident receiv	red orders for Medrol					
	Pak [a steriod]						
		received 8 mg at 6 a.m.					
		d 4 mg at noon and 6					
	p.m						
	l ·	received 8 mg at 8 p.m.					
		a.m., noon, 6 p.m.					
	1	received 4 mg at 7					
		•					
		o.m., and 8 p.m.					
		received 4 mg at 7					
	a.m., noon and	•					
		received 4 mg at 7 a.m.					
	and 8 p.m.						
	On 11/20/12 -	received 4 mg at 7 a.m.					
	Review of the	11/13/12 Weekly					
	Nursing Summ	nary and Skin					

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Event ID: N5L711

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155165	B. WIN			12/18/	2012
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
DI) (ED) (I	E\A(\) (A O E				STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ompleted at 3:09 p.m.,					
		esident had some					
		[Bilateral Lower					
	_	nce last review; but skin					
		dry and pink with no					
		ptoms] of rash or					
	irritation.						
	Nursing notes between 12/10/12 and 12/12/12 indicated the following: - "12/10/12 5:08 p.m Left message with NP regarding rash and itching. Will continue to monitor.						
		No new orders received					
	at this time reg	garding rash."					
	Loot akin aaaa	coment was completed					
		ssment was completed hich indicated the					
		was warm dry and ness or skin irritation					
	was noted.	less of skill irritation					
	was noted.						
	_"19/11/19 1.4.	4 a.mresident					
		t this time with no s/s of					
	distress noted.						
	-2:28 a.mitc						
		sident is resting at this					
		eriodically gotten up					
		aint of] itching. MD					
		ntinue to monitor.					
	intact"	Skin warm, dry and					
	i iilact						
	"12/12/12 2·56	PMSkin is warm					
		i iviOniii is Wallii					
	and dry."		1				I

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE COMPL	
		155165	A. BUIL B. WING			12/18/	2012
	ROVIDER OR SUPPLIEF			586 EAS	DDRESS, CITY, STATE, ZIP CODE STERN BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	and intact." On 12/14/12 a	p.mskin warm dry at noon, the nursing riewed with LPN #1.					
	record where to was at and sho event to docume indicated she was at a second control of the cont	both nurses did not the location of the rash ould have created an nent on it. She also would check the daily f they documented on rash.					
	checked the darash is on there skin. I looked a lotion and the dit is mainly dry have been more	the LPN indicated "I aily reports and the e, mostly written as dry at her and she has day shift nurse told me skin but there should re of an assessment e where the rash was ked like."					
	was received of p.m. This policy 1. The facility periodically a caccurate, standassessment of functional capa annually"	"Resident Assessment" on 12/17/12 at 2:54 by stated, "Procedure: will conduct initially and comprehensive, dardized reproducible each resident's acity not less than					
	3.1-31(d)(1)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2012	
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE STERN BLVD	
RIVERVI	EW VILLAGE			SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155165	B. WIN			12/18/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				STERN BLVD		
DI\/ED\/I	EW VILLAGE				SVILLE, IN 47129		
KIVEKVI	EW VILLAGE			CLARK	SVILLE, IN 47 129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279 SS=E	483.20(d), 483.20 DEVELOP COMP PLANS A facility must use assessment to de the resident's con The facility must of care plan for each measurable object meet a resident's mental and psychidentified in the control of the care plan must that are to be furnithe resident's high mental, and psychiat would otherw §483.25 but are resident's exercise	PREHENSIVE CARE the results of the evelop, review and revise inprehensive plan of care. develop a comprehensive in resident that includes ctives and timetables to medical, nursing, and inosocial needs that are imprehensive assessment. Institute describe the services inshed to attain or maintain thest practicable physical, thosocial well-being as 183.25; and any services vise be required under not provided due to the e of rights under §483.10, tho refuse treatment under	F02		F279 States that a facility mus use the results of the assessm		01/19/2013
	interview, the fa a care plan was resident who has separate occas for a resident w short-term rehas on going home resident with m issues of non-occupation therapy (Resident resident with characteristics). This def	acility failed to ensure s developed for a			to develop, review and revise the resident's comprehensive plant care. The facility must develop comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental apsychosocial needs that are identified in the comprehensive assessment The care plan mudescribe the services that are be furnished to attain or maintathe resident's highest practical physical, mental, and psychosocial well-being as	he of a and e st to ain	

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIM DDA		00	COMPL	ETED
		155165	A. BUILDING	G	·	12/18/	2012
			B. WING	DEET A	DDDECC CITY CTATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
DI) (ED) (I	E\A/\/\/\\ A OE				STERN BLVD		
RIVERVI	EW VILLAGE			LARKS	SVILLE, IN 47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREI	CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TA	\G	DEFICIENCY)		DATE
	planning.				required under §483.25; and a		
					services that would otherwise		
	Findings include	de:			required under §483.25 but are		
					not provided due to the reside		
	1 Doviou of th	ne clinical record for			exercise of rights under §483.	10,	
					including the right to refuse treatment under §483.10(b)		
	Resident #152 on 12/13/12 at 4:31				(4). The facility will ensure this		
	·	I the resident was			requirement is met through the	غ	
	admitted to the	e facility on 10/4/12 and			following corrective measures:		
	had diagnoses	s which included, but			Care plans for residents #152,		
	were not limited to: cellulitis/abscess leg and metastatic neoplasm bone and brain.				#81, and #171 were updated a		
					appropriate. Resident #159		
					discharged home.2. All reside	ents	
	and brain.				who have skin integrity		
					impairment, the plan to discha	rge	
		nursing notes between			home, residents with		
		11/20/12 indicated the			non-compliance with therapy,		
	resident had d	eveloped a rash with			who have chronic pain have the potential to be affected. All	ie	
	occasional itch	1.			residents who have a recent s	kin	
					integrity impairment, the plan t		
	Review of the	MD progress notes			discharge home, are	.0	
		on 11/13/12, the Nurse			non-compliant with therapy, ar	nd	
		P] saw the resident due			who have chronic pain will be		
	_	n was a red rash to the			audited by DNS or designee to		
					ensure care plans are current		
	1	nich had started that			appropriate. 3. Residents wh	10	
		nosis the NP gave was			develop a rash will have a care	е	
	"Dermatitis".				plan initiated, by the charge		
					nurse, MDS, or designee, that		
	Review of the	November 2012			reflects the current condition of the skin. Residents who are	1	
	Physician Ord	ers indicated a new			admitted and plan on returning	1	
		eived on 11/13/12 for			home, will have a care plan	,	
		gy 25 mg tablet -			initiated by Social Services or		
		o,			designee. Residents who are		
	initially QID [4 times a day] but then				non-compliant with therapy wil		
		day thru 11/16/12 to			have a care plan initiated by		
	PRN [as needed]. On 11/15/12				Social Services or designee to)	
	through 11/20	12, the resident also			address refusal of treatments.		
	received order	s for Medrol Pak [a			Residents who designates he	or	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	DDIC	00	COMPLETED	
		155165		LDING		12/18/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
DI) (ED) (II	E.A.) (II.) A O E				STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	steroid].				she is in pain, will have a care		
	-				plan initiated that reflects pain		
	Nursing notes	between 12/10/12 and			assessment by the nurse, MD		
	_				or designee. Care plan meetii		
	12/12/12 indicated the following: -"2/10/12 5:08 p.mLeft message with NP regarding rash and itching. Will continue to monitor.				will be held for each resident a		
					minimum each quarter and ca		
					plans updated as necessary b the IDT at that time. Nursing,	^y	
					Social Services, and MDS state	ff	
	-10:17 p.mNo	new orders received			will be in-serviced on The Care		
	at this time reg	garding rash."			Plan Review and Maintenance		
	-"12/11/12 1:44 a.mresident resting abed at this time with no s/s of				Policy (see Attachment A and		
					Attachment 279-1) by the DNS	3	
	distress noted.				and Staff Development		
	-2:28 a.m. itch				Coordinator on or before Janu	ary	
		_			17 th , 2013. 4. The DNS or		
		sident is resting at this			designee will utilize the Care F	rlan	
	•	eriodically gotten up			Audit Tools (see Attachment 279-3 and Attachment 279-2)	to	
		g. MD aware. Will			ensure that any resident that h		
	continue to mo	onitor."			a skin integrity impairment, the		
					plan to discharge home, are		
	Documentation	n was lacking of a care			non-compliant with therapy, or		
		dressed the red rash on			who have chronic pain, have a		
	both dates.				comprehensive care plan		
	both dates.				completed as appropriate wee		
	A 10/11/12 Co	ro Dian only addressed			for 4 weeks, then monthly for 6		
		re Plan only addressed			months, then quarterly thereaf		
		s being at risk for skin			These audits will be reviewed		
		further breakdown due			during the facility's quarterly C		
	to: need for as	sistance with bed			meetings. If a threshold of 95' is not met, the plan of action w		
	mobility, incon	tinence, complicated by			be adjusted accordingly by the		
	impaired cogni	ition with approaches			CQI committee. 5. The above		
		vas not limited to:			corrective measures will be		
	•	ocument skin condition			completed on or before Janua	ry	
		needed. Notify MD of			17 th , 2013.		
		•					
		ngs. Preventative					
	treatment as o	raerea."					
	On 12/14/12 a	t noon, LPN #1					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING	
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
586 EASTERN BLVD	
RIVERVIEW VILLAGE CLARKSVILLE, IN 47129	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLET	NC
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	
indicated the care plans should have	ļ
been updated to address the	
resident's skin rash issues.	ļ
2. Review of the clinical record for	ļ
Resident #159 on 12/17/12 at 10:09	ļ
a.m., indicated the resident was	ļ
admitted on 9/21/12 and had	
diagnoses which included: chronic	ļ
airway obstruction - chronic with	
exacerbation; bipolar disorder,	
agoraphobia with panic disorder; post	
traumatic stress disorder, anxiety	ļ
state, chronic pain, and	ļ
schizophrenia.	ļ
A Social Services note dated 9/26/12	ļ
at 2:30 p.m., indicated "Resident	ļ
plans to live with [name of family	ļ
member] upon d/c from facility"	ļ
A Social Services note dated 9/26/12	ļ
at 2:27 p.m., indicated "spoke with	ļ
resident at length regarding some	ļ
concerns she is experiencing. She	
stated that she wanted to d/c	
[discharge] to [name of facilities]. She	
is currently under the care of therapist	
[name of agency]. The resident	
requested that I speak with her	
therapist about her d/c plans and any	
other concernsResident has an	
apartment that is in her name, but	ļ
[name of person] was living there	
now. She does not want to go back to	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155165	B. WIN			12/18/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIEI	R		586 EAS	STERN BLVD		
	EW VILLAGE				SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	sons of it having mold					
		u [follow up] with					
	resident for en	•					
		l any new or existing					
	concerns or pr	oblems."					
	A Social Servi	ces note dated					
	11/27/12 at 3:1	17 p.m.,"Res came to					
	writer to discuss d/c plans. She stated that she wants to leave the facility in a couple of weeks and has secured an assisted living apartment. Writer						
	_	ent that all d/c planning					
		dinated before her					
		continue to f/u with d/c					
	_ ·	No further notes could					
	be located.	TVO TUTTICI TIOLOGO GOGIG					
	be located.						
	During an inter	rview with the resident					
	_	10:00 a.m., she					
		•					
		was going to be					
	_	m the facility on					
	12/21/12.						
	l .						
		view with the resident					
		1:30 p.m., indicated					
		ing on going to a new					
	_ ·	ation on 12/20/12 and					
	_	ements and consents					
	had been deve	eloped and set-up by					
	the facility Soc	ial Worker, MD and a					
	case worker from	om an outside agency.					
		-					
	Review of the	9/28/12 Admission					
	MDS [Minimun	n Data Set]					

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Event ID: N5L711

Facility ID: 000082

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155165	B. WIN			12/18/	2012
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			STERN BLVD		
RIVERVI	EW VILLAGE				SVILLE, IN 47129		
(X4) ID	CHMMADVC	TATEMENT OF DEFICIENCIES		ID	,	I	(V5)
PREFIX		H DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	``	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		dicated: Resident					
	I	discharged to the					
	community.						
	No sava plan a	avild ha lagated which					
	•	ould be located which					
		charge Planning.					
	During an interview with Social Worker # 1 on 12/17/12 at 1:35 p.m.,						
	she indicated that she had only just started working in the facility 11/1/12 and that the resident came in before						
		ne indicated that there					
		een a care plan by					
		s right after admission					
	as the resident	t's code status and					
	discharge statu	us are to be done right					
	away on a care	e plan.					
	Review of th	ne clinical record for					
	Resident #81 o	on 12/17/12 at 2:00					
	p.m., indicated	the resident was					
	admitted from	the hospital on 10/4/12					
	and had diagn	oses which included,					
		mited: senile dementia,					
		order with depressed					
		neralized anxiety					
	disorder.						
	SW [Social Wo	orker] #1 note dated					
	_	11 p.m., "Spoke with					
		on about d/c planning					
		it course of therapy.					
		d that before her					
		e independently					
	cooked, cleane	ed, bathed, toileted,					

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Event ID: N5L711

Facility ID: 000082

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	VT OF DEFICIENCIES OF CORRECTION	f '		COMPL	(X3) DATE SURVEY COMPLETED 12/18/2012		
	PROVIDER OR SUPPLIER			586 EA	ADDRESS, CITY, STATE, ZIP CODE STERN BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	do all of the ab encouraged resessions to me Will continue to and assess for concerns." A SW #1 note a.m. indicated resident's son non-compliance Therapy, Social [executive direction of the continues of the co	e issues with therapy. Il Services and ED ctor] will attend." nal Therapy] Therapist Discharge Summary: atient did not make gress towards goals. djust treatment plans is to encourage patient atient with					

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Event ID: N5L711

Facility ID: 000082

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155165	B. WIN	IG		12/18/2012
NAME OF P	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					STERN BLVD	
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		mpliant with most				
		by tasks; decreased				
	motivation to p	апісірате.				
	A 10/25/12 DT	(Dhysical Thorapy)				
	A 10/25/12 PT {Physical Therapy] note indicated "Patient needs max					
		it to participate with				
	. •	py and frequently				
	refused therap					
		therapy explained.				
	Patient has pro					
	strengthening	_				
		th transfers or showing				
	1 ' ' '	gress with gait."				
	Consistent prog	Jicos With gait.				
	PT [Physical T	herapy] Therapist				
		Discharge Summary:				
		s motivation to				
		nerapy. D/C from				
		py services secondary				
	1	d maximum benefits				
	from therapy a					
	A care plan wh	ich addressed the				
	resident's non-	compliance behaviors				
	of refusing the	apy was lacking.				
	4. Record revie	ew for Resident #171				
	was done on 1	2/12/12 at 1:45 p.m.				
	She was admit	ted on 12/10/12 with				
	diagnoses which	ch included but were				
	not limited to: [Diabetes, high blood				
	pressure, anxie	ety disorder, chronic				
	airway obstruc	tion, dementia, chronic				
		and ischemic heart				
	disease. The	pain assessment done				

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Event ID: N5L711

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL 12/18/	ETED	
		155165	B. WIN	_		12/18/	2012
	PROVIDER OR SUPPLIER	8		586 EAS	ADDRESS, CITY, STATE, ZIP CODE STERN BLVD SVILLE, IN 47129		
(V4) ID	CLIMMADY C	TATEMENT OF DEFICIENCIES		ID	- , -		(V5)
(X4) ID PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	3	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		DATE
		dicated this resident					
	-	frequently but there					
	•	or any kind of pain					
	medication.						
	medication.						
	Interview with the resident on						
		35 p.m., she indicated					
		ant neck pain. She					
		nedicine helps but does					
		y. During this interview					
	a nurse came in the room to give her medications. She told the nurse						
		The nurse told her					
	•	the doctor and get an					
		ain medication. As of					
		:49 p.m., there was no					
		that the doctor had					
		nis resident needed					
	something for						
		pain.					
	Orders were re	eceived on 12/17/12 at					
		the Medical Records					
	•	e indicated the doctor					
	_	m on Friday (12/14/12).					
	•	no order for any pain					
	medicine.	no order for any pain					
	medicine.						
	On 12/17/12 at	t 2:30 n.m. we					
		y of an order for					
	•	g 2 tablets every 6					
		ed for pain. The date					
	on the order wa	•					
	on the order W	as 12/11/12.					
	Δs of 12/17/12	at 2:30 p.m., there					
		an for the chronic pain					
	was no care pr	an for the chilothic pain					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL		
11.12111111		155165		LDING		12/18/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	I	·
NAME OF P	ROVIDER OR SUPPLIER				STERN BLVD		
	EW VILLAGE				SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	this resident ha	· · · · · · · · · · · · · · · · · · ·		IAG	,		DATE
	tillo resident ne	iu.					
	On 12/14/12 at	: 1:20 p.m., LPN #1					
		py of the facility's					
	•	on "Care Plan Review					
	_	ce Process." Review of					
	the policy at thi	is time included, but					
	was not limited	to: "Policy: It is the					
		cility that each resident					
		nprehensive care plan					
	-	ed on comprehensive					
		he care plan will					
		rable goals and					
	•	ic interventions based					
		eds and preferences to					
	-	sident's highest level of					
		ocedure:Care plan s, and interventions will					
	•	sed on changes in					
	-	sment/condition,"					
	resident asses	oment condition,					
	3.1-35(a)						
	3.1-35(b)(1)						
	,,,,						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155165	B. WING		12/18/2012		
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE			
DI) (ED) (I	E\A(\) (A O E			STERN BLVD			
RIVERVI	EW VILLAGE		CLARK	SVILLE, IN 47129			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		

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Facility ID: 000082

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155165	B. WING		12/18/2012		
	PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
F0280 SS=D	483.20(d)(3), 48 RIGHT TO PAR CARE-REVISE The resident ha incompetent or or incapacitated ur participate in pla changes in care A comprehensive developed within of the comprehe by an interdiscip the attending ph with responsibilit appropriate staff by the resident's practicable, the the resident's fa representative; and revised by a after each asses A. Based on interview, the the Social Set Discharge Pla resident's plan after rehabilitat long term care affected 1 of 8 social service #81) B. Based on observations a facility failed t revision to addressed	3.10(k)(2) TICIPATE PLANNING CP Is the right, unless adjudged otherwise found to be adder the laws of the State, to anning care and treatment or and treatment. The care plan must be a 7 days after the completion ensive assessment; prepared of otherwise assessment; prepared of otherwise assessment; prepared of other findisciplines as determined as needs, and, to the extent participation of the resident, mily or the resident's legal and periodically reviewed a team of qualified persons	F0280	F280 States that the resident the right, unless adjudged incompetent or otherwise fou be incapacitated under the la of the State, to participate in planning care and treatment changes in care and treatment comprehensive care plan mu developed within 7 days after completion of the comprehen assessment; prepared by an interdisciplinary team, that includes the attending physic a registered nurse with responsibility for the resident, other appropriate staff in disciplines as determined by resident's needs, and, to the extent practicable, the participation of the resident, to	has 01/19/2013 Ind to ws or nt.A st be of the sive dian, and the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLETED
		155165	B. WIN			12/18/2012
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R			STERN BLVD	
RIVERVI	EW VILLAGE				SVILLE, IN 47129	
					T	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	· ·	DATE
	·	e in interventions after			resident's family or the resider legal representative; and	ILS
		dent's change in			periodically reviewed and revision	sed
		s affected 3 of 11			by a team of qualified persons	l l
	residents reviewed for care plan				after each assessment. The	
	revisions. (Res	sidents #64, 31 and			facility will ensure this	
	108)				requirement is met through the	l l
	,				following corrective measures	
	Finding include	es:			Resident # 81, #64, #31 and #	
					care plans and interventions heen updated to reflect the	ave
	A. Review of the clinical record for				resident's current status. 2. A	AII
					residents who have the plan to	
	Resident #81 on 12/13/12 at 4:31 p.m., indicated the resident was				discharge home, who has had	
	l •				recent fall, or a change in	
		e facility on 10/4/12 and			condition have the potential to	be
	_	which included, but			affected. All residents who ha	-
		d to: cellulitis/abscess			the goal to discharge home, h	l l
	leg and metast	tatic neoplasm bone			experienced a recent fall or ha	l l
	and brain.				had a recent change in conditi will be audited by DNS or	OII
					Designee to ensure the accura	acv
	Review of Soc	ial Worker #1's note			of the resident's care plan. 3.	-
	dated 10/15/12	2 indicated: "res			resident experiences a fall, fal	l l
	[resident] d/c [discharge] plans are to			interventions will be reviewed	
	go home upon	<u> </u>			revised, care plan will be revis	
	therapy."				and any new orders will become	l l
	unorapy.				part of the care plan. The DNS MDS, or Designee will be	ο,
	A Social Works	er #1 note dated			responsible for the care plan	
					revision. Any new fall interver	ntion
		11 p.m.,. indicated:			will be incorporated into the ca	l l
		sident and son about			plan and C.N.A. assignment	
	1	planning and her			sheets. The Social Services	
		of therapy. Res			Director or designee will comp	
		ed that before her			upon discharge the discharge	
	admission, she	e independently			home check list (see Attachme 280-1). The IDT will review th	
	cooked, cleane	ed, bathed, toileted,			form to ensure all arrangemen	
	and walked. S	he expressed desire to			are met. Any resident who is	
		oove before d/c. Writer			designated to discharge home	
	encouraged re	s to attend therapy			and, it is identified that they ar	e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE S	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155165	B. WIN			12/18/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			STERN BLVD		
DI\/ED\/I	EW VILLAGE				SVILLE, IN 47129		
IXIVLIXVI	LW VILLAGE			CLAIN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sessions to me	eet her short term goal			unable to do so, the resident's		
	Will continue to encourage, motivate and assess for any changes or concerns."				care plan will be updated by th	ie	
					Social Services Director or designee at that time to ensure	0	
					proper plans are in place. All	5	
					nursing staff and IDT will be		
	Social Worker	#1's note dated			in-serviced on the Care Plan		
		5 a.m., indicated: "Set			Review and Maintenance		
					Process (see Attachment A ar		
		h resident's son			Attachment 280-2) by the DNS	3	
		non-compliance issues			and Staff Development		
	with therapy. Therapy, Social Services and ED will attend."				Coordinator on or before Janu	ary	
					17 th , 2013. 4. The DNS or		
					designee will utilize the Continuous Quality Improvement	ent	
	A 10/16/12 Ad	mission MDS [Minimum			Care Plan Review tool (see	CITC	
	Data Set] Asse	essment indicated the			Attachment 280-4)and the		
	resident score	d a 14 on her BIMS			Continuous Quality Improvement	ent	
	 [brief interview	of mental status] test -			Care Plan Updating tool (see		
	_	act; no mood or			Attachment 280-3) to ensure t	hat	
	behavior issue				care plans are accurate and		
	Deliavioi issue	5,			updated as appropriate weekly	y for	
		ahaana Dhanii aaatian af			4 weeks, then monthly for 6	itor	
		charge Plan" section of			months, then quarterly thereaf These audits will be reviewed		
		active discharge plan			during the facility's quarterly C		
	was not occurr	ing for resident's return			meetings. If a threshold of 95		
	to the commur	nity.			is not met, the plan of action w		
					be adjusted accordingly by the		
	A 10/17/12 Ca	re plan was developed			CQI committee. 5. The above		
		plans to return to the			corrective measures will be		
		ioal : Resident will be			completed on or before Janua	ry	
	,	her home. Approaches:			17 th , 2013.		
	_	sident and family					
		-					
		ition to the community					
	(home care, DME [durable medical						
		OWs [meals on					
	wheels], etc); (Offer home evaluation					
	as appropriate	; referral to outside					
	agency as app	ropriate."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155165	A. BUI	LDING	00	COMPL	
		133103	B. WIN			12/18/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE STERN BLVD		
RIVERVI	EW VILLAGE				SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	· ·				CROSS-REFERENCED TO THE APPROPRIA	TE	
PREFIX TAG	The OT [occup Therapist Prog Summary date "The patient d progress toward adjust treatment techniques to participation. For actions and versions and versions with attential to participation. For actions and versions with poor motion task requiring Long term Canton The ST [speed Progress and dated 11/9/12 did not make some week towards to]noncompliate Patient non-contasks; decrease participate." The PT [physis Progress and dated 11/1/12 motivation to pure D/C from Physis secondary patients."	encourage pt Pt with inappropriate erbalization towards contacted multiple empted interventions. Pt vation and initiation of max vc's [verbal cues]. re" The therapist] Therapist Discharge Summary indicated "The patient significant progress this goals d/t [due nce with ST POC. Empliant with most ST sed motivation to cal therapist] Therapist Discharge Summary indicated "Needs participate in therapy. Sical Therapy services itent reached maximum therapy at this time - 24		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155165	B. WIN			12/18/	2012
NAME OF I	PROVIDER OR SUPPLIE	ER .			ADDRESS, CITY, STATE, ZIP CODE		
DIVEDVI	EW VILLAGE				STERN BLVD SVILLE, IN 47129		
	1				SVILLE, IIN 47 129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1110	1	nysical Therapy note		1110			DITTE
		ient needs max					
	[maximum] encouragement to participate with Physical Therapy and						
		used therapy, even after					
		therapy explained.					
	l '	ogressed with					
	•	goal but is not					
		ith transfers or showing					
		gress with gait."					
	Documentation was lacking of the						
	care plan havi	ing been updated to					
	reflect the res	ident now requiring long					
	term care inst	ead of going home.					
	_	rview on 12/17/12 at					
		Social Worker #1, she					
		didn't know why she					
		ented on the resident					
	since the Nov	ember note.					
	0= 40/44/40	4.4.00 m m					
		at 1:20 p.m., LPN #1					
		opy of the facility's					
	and Maintena	on "Care Plan Review					
		ocedure:Care plan					
		als, and interventions will					
		ased on changes in					
	l '	ssment/condition,"					
		nt #64's record was					
		2/13/12 at 3:05 p.m.					
		dicated Resident #64					
		s that included, but were					
	_	muscle weakness,					
	1		1				

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Facility ID: 000082

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155165		LDING	00	12/18/	
NAME OF F	DROVADED OD GUIDDI IEI		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEF	C			STERN BLVD		
	EW VILLAGE				SVILLE, IN 47129		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	difficulty in wal dementia with	nigh blood pressure, disease, atrial					
	Assessment (National indicated Residual moderately implied for daily decisional decisions)	nimum Data Set MDS) dated 8/28/12 dent #64 was paired in cognitive skills on making and has had hission with minor					
	1:00 p.m., indictransferring se to bed. Reside floor. Fall unwidenies any paithis time. 0 maresident on use assistance, als socks during tr	s, dated 12/13/12 at cated: "Resident of the from w/c (wheelchair) ent slid from chair to eitnessed, resident of the from r/t (related to) fall at carks noted. Educated the of call light for to wear nonskid transfer. Call light in ont[inue] to monitor					
	indicated Resideroom on 12/13 was found sitting the bed. She I	tion, dated 12/13/12, dent #64 fell in her /12 at 1:12 p.m. and ng on the floor next to had been dressed in earing gripper socks					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155165	B. WIN			12/18/	2012
		<u> </u>	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			STERN BLVD		
DI\/ED\/I	EW VILLAGE				SVILLE, IN 47129		
IXIVLIXVI	LVV VILLAGE			CLAININ	SVILLE, IIV 47 129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and the fall wa	s unwitnessed. The					
	resident didn't	complain of pain and					
	had not been i	ncontinent. There was					
	no clutter or environmental factors and the new intervention was "Resident will attend dining room [for						
		atteria animg room from					
	meals]". Progress notes, dated 11/24/12 at						
	1						
	· ·	dicated: "Resident					
	found in the floor setting up. Resident						
	stated she slid out of her bed trying to						
	get a pencil. R	esident had on					
	non-skid socks	s. Educated resident					
	on using the ca	all light when need					
	help transferrir	ng. Resident has 0					
		ted. Will cont to					
	monitor during						
	I mornior during	Silit.					
	A fall investige	tion, dated 11/24/12,					
	1						
		dent #64 fell on					
		:28 a.m. The fall was					
		he resident had been					
	, ,	then was found sitting					
	on the floor. T	he resident was					
	wearing non sl	kid socks, did not					
		in, and no injuries were					
		e resident stated she					
		get a pencil" and was					
		o be incontinent at the					
		The new intervention					
		(sic) resident on using					
	call light for as	sistance".					
	The intervention	on for use of the call					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155165	A. BUILDING B. WING			COMPLETED 12/18/2012	
	PROVIDER OR SUPPLIER		p. 1111	STREET A	ADDRESS, CITY, STATE, ZIP CODE STERN BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
PREFIX	light was already plan, and no of initiated. Progress notes 9:53 a.m., indice DNS (Director of Therapy, Dietar Resident had a 11/24/12 at 113 at 1138 am, MI Prior to fall resi When staff enter was sitting on the She was dressed on. Full body a completed per reported she drewas trying to pi Therapy to screen device."	dy part of the care her interventions were her intervention at 11/26/12 at 12/26/12 at 12/		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
	yelled for nurse by room. Resid leaned up again was trying to tra w/c. Resident v skid, or shoes a Resident stated head. No injurit resident on usin	e as nurse was passing dent found on the floor nest her w/c. Resident ansfer self form bed to was not wearing non at time of fall. If she did not hit her es noted. Educated ng call light, and the wearing non skid attire.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155165	B. WIN			12/18/2012	
			В. W II V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		586 EAS	STERN BLVD		
RIVERVI	EW VILLAGE				SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	_	TAG			DATE
	supervisor. W	ill cont to monitor."					
	A fall investigal indicated Resident 11:43 a.m. a unwitnessed. in bed, was for her wheel chair dressed with shad no complain injuries, and strout of bed to go The resident hat the time of the intervention was on the resident the use of call skid attire." The intervention light was alreat and no other in initiated. Review of care indicated a goan on injury related Interventions were not limited. Resident to attime als. 11/26/for use of a reademove w/c from the sident to attime als. 11/26/for use of a reademove w/c from the sident to attime als. 11/26/for use of a reademove w/c from the sident to attime als. 11/26/for use of a reademove w/c from the sident to attime als. 11/26/for use of a reademove w/c from the sident to attime als. 11/26/for use of a reademove w/c from the sident to attime als. 11/26/for use of a reademove w/c from the sident to attime als. 11/26/for use of a reademove w/c from the sident to attime als. 11/26/for use of a reademove w/c from the sident to attime als. 11/26/for use of a reademove w/c from the sident to attime als. 11/26/for use of a reademove w/c from the sident to attime als.	tion, dated 9/22/12, dent #64 fell on 9/22/12 and the fall was The resident had been und sitting up against r in her room, and was ocks on. The resident ints of pain, had no ated she was "getting et in her wheel chair". ad not been incontinent he fall. The new as to put tennis shoes t, and "Educated res on light and wearing non on for use of the call dy part of the care plan interventions were					
		get up in am. 4/18/12:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COMI	E SURVEY PLETED 8/2012	
	PROVIDER OR SUPPLIE	R	586 E	T ADDRESS, CITY, STATE, ZIP COD EASTERN BLVD RKSVILLE, IN 47129	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	night. 4/09/12 lowest position Encourage and use call light. participation in Fall risk asses risk contributor hypotension, perovide appropriate appropriate as walked floor, alarms of assistance for During an interference had been During an interference had told the was in the IDT #64 needed a check to see withat.	rview on 12/18/12 at cupational Therapist #5 ooked for a screening but couldn't find where				

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		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155165	B. WING		12/18/2012
NAME OF F	DROWNER OF GUIDA IEI		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	X	586 EA	STERN BLVD	
RIVERVI	EW VILLAGE		CLARK	(SVILLE, IN 47129	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	3:13 p.m., the	Director of Health			
	Services (DHS	s) indicated that OT			
	(occupational t	therapy), PT (physical			
	therapy), and \$	ST (speech therapy)			
	had determine	d the reacher would not			
	be an appropri	ate intervention, that			
		plated fall and the			
	interventions in	n place were			
	appropriate.				
	B. 2. Record review for Resident				
	#108 was done on 12/13/12 at 3:05				
	p.m. This resi	dent was admitted on			
	l '	n readmitted on			
	9/27/12 after s	he had been			
	hospitalized or	n 9/24/12. Her			
		uded but were not			
	_	phageal reflux, anxiety,			
		ctive lung disease			
		nia, and depression.			
	, (22. 2), (3)	,			
	According to the	ne Progress Notes			
	_	through 9/24/12			
		was having confusion			
		tion. There were no			
		out into place on her			
	care plan since	•			
	Jaio pian sino	J J, 10/ 12.			
	B. 3. Record r	review for Resident #31			
		2/17/12 at 4:10 p.m.			
		tted on 2/28/2007. Her			
		uded but were not			
	limited to: Osteoarthrosis, dementia with depression and behaviors,				
	-	er, difficulty walking,			
		kes, convulsions,			
	i listory or stroi	NES, CONVUISIONS,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155165	B. WIN	IG		12/18/	2012
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
DIVEDVIII	E\A(\) (A O E		586 EASTERN BLVD CLARKSVILLE, IN 47129				
RIVERVII	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		essive disorder and					
	hearing loss. During review of the progress notes it was found that this						
		ad 2 falls earlier this					
	,	nd 12/7/12). It was also					
	noted that the care plan for falls had not been updated since 11/4/11.						
	There were no new interventions in						
	place since the 2 falls.						
	Interview with LPN #2 on 12/17/12 at						
	1:30 p.m., she indicated changes are						
	•	are plans when there is					
		e resident's condition					
	_	s. "It is the nurses					
		o update them or be					
		or of Nursing is made					
		can have someone					
	update it."						
	о р жиз						
	A policy and p	rocedure for a "Fall					
		Program", with a					
	_	f 6/2012, indicated					
		e policy of American					
		unities to ensure					
	residents resid	ing within the facility					
		aximum physical					
		ough the establishment					
	of physical, en	vironmental, and					
	psychosocial g	uidelines to prevent					
	injury related to	o falls. Procedure4.					
	A fall event wil	l be initiated as soon as					
	the resident ha	s been assessed and					
	cared for. The report must be						
	completed in fu	ull in order to identify					

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	DF CORRECTION IDENTIFICATION NUMBER: 155165	A. BUILE B. WING		00	COMPL 12/18/	ETED	
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
	possible root causes of the fall and provide immediate interventions. An entry will be completed in the EMR (Electronic Medical Record) addressing the fall, any injuries, physician and family notification, and interventions initiated. 5. All falls will be discussed by the interdisciplinary team the next business day morning after the day of the fall to determine other possible interventions to prevent future fallsThe care plan will be reviewed and updated, as necessary." 3.1-35(d)(2)(B) 3.1-35(e)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 12/18/2012	
	PROVIDER OR SUPPLIEI	<u>l</u>	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PRE	FIX PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION DATE
F0309 SS=D	483.25 PROVIDE CARE HIGHEST WELL Each resident mu must provide the services to attain practicable physi psychosocial wel the comprehensi care. A. Based on re- interview the fa	/SERVICES FOR BEING ust receive and the facility necessary care and or maintain the highest	F0309	F309 States that each must receive and the fi provide the necessary services to attain or magnetic services.	acility must care and aintain the	01/19/2013
	services she n became confus notification to t assessment or it had been go	eeded in that when she sed there was no he doctor and no care plan update until ing on for 5 days. This 0 residents reviewed and services.		highest practicable phymental, and psychosod well-being, in accordar comprehensive assess plan of care. The facilitiensure this requirement through the following of measures:1. Resident current condition has be reviewed by the IDT te communicated to physfamily. Additionally, residential control of the communicated to physfamily.	cial nce with the sment and ty will nt is met corrective t #108 peen eam and sician and	
	interview, the f a resident with treatment to al deficient practi	ecord review and facility failed to ensure a skin rash received leviate the itching. This ce affected 1 of 2 wed for skin conditions.		#108 care plan has be updated. The DNS as resident #152 and rash cleared.2. All resident a change in condition a skin integrity have the be affected. All reside have a recent change condition, or a recent i	en sessed h has s who have or impaired potential to ints who in mpaired	
	was done on 1 This resident v	de: ew for Resident #108 2/13/12 at 3:05 p.m. vas admitted on 8/3/12 mitted on 9/27/12 after		skin integrity event, wil audited by the DNS or to ensure that family a physicians have been about change of condicare plans are updated residents with impaired	designee, nd notified tion and d and that	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00		00	COMPLETED	
		155165	B. WIN			12/18/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			STERN BLVD		
RIVERVI	EW VILLAGE				SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	she had been l	nospitalized on			integrity have appropriate		
	9/24/12. Her d	liagnoses included but			treatments.3. The charge nur	se	
		d to: esophageal reflux,			who identifies the change in		
		c obstructive lung			condition will contact the	. 4	
	•	D), anemia, and			resident's physician and family communicate the change. The		
	· · · · · · · · · · · · · · · · · · ·	2), anemia, and			charge nurse will document th		
	depression.				nurse's assessment/	•	
					actions/interventions in the		
		was experiencing			nurses' notes and will add to t	he	
		disorientation. The			daily charting. The DNS or		
	facility docume	nted it was happening			designee will review		
	but there was r	no assessment done			documentation to ensure		
	and there was	no documentation in			physician and family are notific		
	the record of th	ne physician			and assessment is completed		
		ne resident was			the assessment is not comple appropriate action will be take		
		days before the doctor			Residents who develop a rash		
		-			a recent skin integrity event, w		
		she was sent to the			have a skin assessment		
	hospital.				completed by the charge nurs	е	
					immediately upon notification.		
	Interview with I	LPN #5 on 12/17/12 at			The DNS or designee will rev		
	11:00 a.m., she	e indicated this resident			skin assessments to ensure the	ne	
	was doing mud	ch better now that she			assessments are completed		
	_	gen on better. There			accurately and completely. The	ne	
		be notification to the			IDT will develop a care plan based on the skin		
	•	inge in condition.			assessment. All nursing and II	DT	
					team will be in-serviced on or	- I	
					before January 17 th , 2013, b	y	
					the DNS and Staff Developme	,	
					Coordinator, on the Skin		
					Management Policy and		
					Procedure, Care Plan Policy,		
					the Change of Condition Polic	у	
					(see Attachment A and	NS	
					Attachment 309-1). 4. The D or designee will utilize the	OVI	
					Continuous Quality Improvem	ent	
					Skin Management Program to		
					(see Attachment 309-5), Chan		
					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155165	B. WING		12/18/2012
			_	ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		EASTERN BLVD	
RIVFRVI	EW VILLAGE			RKSVILLE, IN 47129	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DATE
				of Condition Program tool (s Attachment 309-4), and the C Plan Review tools (see	l l
				Attachment 309-2, 309-3), to	
				ensure that change of conditi	
				care plan review, and impaire	
				skin integrity assessments ar treatments are completed as	JU .
				appropriate weekly for 4 wee	ks,
				then monthly for 6 months, th	
				quarterly thereafter. These	
				audits will be reviewed during	
				facility's quarterly CQI meeting If a threshold of 95% is not referred.	· I
				the plan of action will be adju	<i>'</i>
				accordingly by the CQI	
				committee. 5. The above	
				corrective measures will be	
				completed on or before Janu	ary
	D D	ha aliminal managed for		17 th , 2013.	
		he clinical record for			
		? on 12/13/12 at 4:31			
	I •	I the resident was			
		e facility on 10/4/12 and			
	had diagnoses	s which included, but			
	were not limite	ed to: cellulitis/abscess			
	leg and metas	tatic neoplasm bone			
	and brain.				
	.				
		between 12/10/12 and			
		ated the following:			
	-"12/10/12 5:0	8 p.m Left message			
	with Nurse Pra	actitioner [NP] regarding			
	rash and itchin	ng. Will continue to			
	monitor.	-			
		No new orders received			
	at this time reg				
		garaniy rasii.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155165	B. WING		12/18/2012
			_	ET ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIE	ER		EASTERN BLVD	_
RIVFRVI	IEW VILLAGE			RKSVILLE, IN 47129	
	1			1	1 775
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD BE NOT THE PROVIDER OF THE PROVIDER	
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	
IAU	-		TAG		DATE
		14 a.mresident			
	_	at this time with no s/s of			
	distress noted				
		ching and rash			
		sident is resting at this			
		periodically gotten up			
		g. MD aware. Will			
	continue to m	onitor."			
	On 12/17/12 a	at 12:25 p.m., LPN #1			
	indicated "I checked the daily reports				
		s on there, mostly			
		skin. I looked at her and			
	1	nurse said it is mainly			
	just dry skin."	idise said it is mainly			
	Just dry skiri.				
	No document	ation was found of the			
		otion to the resident's			
		ith dry skin and itching.			
		ian ary chair and iterining.			
	During an Inte	erview with LPN #2 at			
	1:00 p.m., on	12/14/12, she indicated			
	she had just o	completed a full skin			
	assessment c	on the resident per			
	request as it v	vas observed the			
		a rash. She indicated			
		e assessment, nothing			
	_	I on the resident at this			
		she believed it was just			
		reviewed the MD orders			
	•	that the resident did not			
have any specific orders for lotion to					
	1 '				
		•			
	treat dry skin. that the reside	The LPN also indicated ent did have a tendency dry skin and make it			

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PRINTED: 01/22/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155165	B. WING		12/18/2012
NAME OF E	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP CODE	
		R		ASTERN BLVD	
RIVERVI	EW VILLAGE		CLAR	(SVILLE, IN 47129	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	red.				
	3.1-37(a)				

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Event ID: N5L711

Facility ID: 000082

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLE		ETED		
		155165	B. WIN			12/18/2012	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
חו/רח/וו	EW VILLAGE				STERN BLVD		
RIVERVII	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323	483.25(h)						
SS=D	FREE OF ACCID	ENT					
	HAZARDS/SUPE	RVISION/DEVICES					
	•	ensure that the resident					
		ains as free of accident					
	•	sible; and each resident					
	receives adequate						
	assistance device	es to prevent accidents.					
			F03	23	F323 States that the facility mu	ust	01/19/2013
	Based on recor	rd review, observation,			ensure that the resident		
	and interview, t	the facility failed to			environment remains as free o		
	ensure residen	ts were free from falls			accident hazards as is possible	e;	
		s in that 2 residents			and each resident receives		
		o appropriate, new			adequate supervision and assistance devices to prevent		
		• • •			accidents. The facility will ensu	ırα	
		fter the falls to prevent			this requirement is met through		
		nis affected 2 of 4			the following corrective	•	
	residents review	wed for supervision to			measures:1. Resident #64 ar	nd	
	prevent accide	nts. (Residents # 64			#31's fall interventions and car	е	
	and #31)				plans were reviewed and		
	,				updated. 2. All residents who		
	The findings in	clude.			have experienced a recent fall		
	The infamge in	olddo.			have the potential to be affected		
	4 Danidant #0	Ale necessarye			All residents with recent falls v		
	1. Resident #6				be audited by DNS or Designe	e	
		2/13/12 at 3:05 p.m.			to ensure care plans and	at a	
	The record indi	cated Resident #64			interventions are still appropria and in place.3. If resident	ale	
	had diagnoses	that included, but were			experiences a fall, fall		
	not limited to, n	nuscle weakness,			interventions will be reviewed	and	
		ry tract infection,			revised, care plan will be revise		
	•	king, psychosis, senile,			and any new orders will become		
	dementia with l				part of the care plan. The		
					DNS/Designee will be respons	ible	
		nigh blood pressure,			for the care plan revision. Any	y	
	ischemic heart	·			new fall intervention will be		
	fibrillation, and	intracranial			incorporated into the care plan	1	
	hemorrhage.				and C.N.A assignment		
	ŭ				sheets.Nursing staff will be		
	Δ quarterly Min	imum Data Set			in-serviced on or before Janua	ıry	
	A qualiting Will	iiiiuiii Dala Sel			17 th , 2013, by the DNS and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED		ETED		
		155165	B. WINC			12/18/	2012
			В. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			STERN BLVD		
RIVFRVI	EW VILLAGE				SVILLE, IN 47129		
	ı						
(X4) ID		TATEMENT OF DEFICIENCIES	l ,	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	1	PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG			DATE
	,	MDS) dated 8/28/12			Staff Development Coordinato on the Fall Management)r	
	indicated Resid				procedure (see attachment A	`	
	moderately imp	paired in cognitive skills			All residents who had a fall wi		
	for daily decision	on making and has had			have an immediate interventio		
	falls since adm	nission with minor			initiated. The ASC Fall Event		
	injuries.				be reviewed during the clinical		
	, , , , ,				IDT meeting on the following		
	Progress notes	s, dated 12/13/12 at			business day to ensure		
	. •	cated: "Resident			interventions to the fall are		
	· ·				appropriate. If, during this time the intervention is not	e,	
	transferring self from w/c (wheelchair) to bed. Resident slid from chair to				appropriate, then the IDT team		
					will initiate a more appropriate		
	floor. Fall unwitnessed, resident				intervention. 4. The DNS or h		
	denies any pai	n r/t (related to) fall at			designee will utilize the CQI		
	this time. 0 ma	arks noted. Educated			Quality Indicator Falls		
	resident on use	e of call light for			Management tool (see		
		so to wear nonskid			Attachment F323-1) to ensure		
	· ·	ansfer. Call light in			residents' fall interventions are		
		nt[inue] to monitor			appropriate weekly for 4 week		
	during shift."	interior in the interior			then monthly for 6 months, the		
	during Silit.				quarterly thereafter. These au will be reviewed during the	idits	
					facility's quarterly CQI meeting	10	
	1	tion, dated 12/13/12,			and the plan of action adjusted		
		dent #64 fell in her			accordingly. If a threshold of 9		
	room on 12/13	/12 at 1:12 p.m., and			is not met, the plan of action w		
	was found sitti	ng on the floor next to			be adjusted accordingly by the	;	
	the bed. She I	nad been dressed in			CQI committee. 5. The above	Э	
	clothes and we	earing gripper socks			corrective measures will be		
		s unwitnessed. The			completed on or before Janua	ry	
		complain of pain and			17 th , 2013.		
		ncontinent. There was					
		nvironmental factors					
	and the new in						
		attend dining room [for					
	meals]".						
	Progress notes	s, dated 11/24/12 at					

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Event ID: N5L711

Facility ID: 000082

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
	155165	B. WING		12/18/2012
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE	
חוייבטייו	EWANT ACE		STERN BLVD	
RIVERVI	EW VILLAGE	CLARK	SVILLE, IN 47129	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
TAG	11:34 a.m., indicated: "Resident	IAG		DATE
	found in the floor setting up. Resident			
	stated she slid out of her bed trying to			
	get a pencil. Resident had on			
	non-skid socks. Educated resident			
	on using the call light when need			
	help transferring. Resident has 0			
	injurys (sic) noted. Will cont to			
	monitor during shift."			
	,			
	A fall investigation, dated 11/24/12,			
	indicated Resident #64 fell on			
	11/24/12 at 11:28 a.m. The fall was			
	unwitnessed, the resident had been			
	resting in bed, then was found sitting			
	on the floor. The resident was			
	wearing non skid socks, did not			
	complain of pain, and no injuries were			
	observed. The resident stated she			
	was "trying to get a pencil" and was			
	not observed to be incontinent at the			
	time of the fall. The new intervention			
	was "Educted (sic) resident on using			
	call light for assistance".			
	The intervention for use of the call			
	light was already part of the care			
	plan, and no other interventions were			
	initiated.			
	Progress notes, dated 11/26/12 at			
	9:53 a.m., indicated: "Fall review with			
	DNS (Director of Nursing Services),			
	Therapy, Dietary, and Unit Manager.			
	Resident had an unwitnessed fall on			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165		A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 12/18/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE STERN BLVD SVILLE, IN 47129	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	at 1138 am, MI Prior to fall resi When staff ento was sitting on the She was dress on. Full body completed per reported she downs trying to pit Therapy to screed evice." Progress notes 10:30 a.m., indevice." Progress notes 10:30 a.m., indevice." Progress notes 10:30 a.m., indevice. Resident states the states of the stat	d she did not hit her les noted. Educated ng call light, and the vearing non skid attire.					

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Event ID: N5L711

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155165	B. WINC	·		12/18/	2012
NAME OF P	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	ints of pain, had no					
		ated she was "getting					
		et in her wheel chair".					
		ad not been incontinent					
		he fall. The new					
		as to put tennis shoes					
		t, and "Educated res on					
		light and wearing non					
	skid attire."						
	The interverti-	on for use of the sell					
		on for use of the call					
		dy part of the care plan					
		terventions were					
	initiated.						
	Peview of care	plans dated 3/3/12					
		al of "Resident will have					
	no injury relate						
	, ,	vith dates included, but					
		d to: "12/13/12:					
		end Dining Room for					
		12: Therapy to screen					
		acher device. 9/24/12:					
		om bedside. 9/24/12:					
		light. 7/9/12: 10:30					
		get up in am. 4/18/12:					
		n light on during the					
	•	Keep foot of bed at					
	•	. 5/27/11 indicated:					
	•	d remind resident to					
	_	Encourage continued					
	_	ordered therapies.					
		sment. Observe for fall					
		s such as medications,					
	nypotension, p	ain, unsteady gait.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155165	B. WING	;		12/18/	2012
NAME OF P	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOTT EIET				STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		oriate assistive devices					
		r, low bed, mats on					
		n chair/bed. Provide					
	assistance for	transfers, bed mobility."					
	During an inter	view on 11/24/12 at					
	•	ech Therapist #4					
		ooked for an evaluation					
		but did not find where					
	one had been						
	one had been	dono.					
	During an inter	view on 12/18/12 at					
		upational Therapist #5					
		ooked for a screening					
		but couldn't find where					
	one had been						
	During an inter	view on 12/18/12 at					
	2:17 p.m., Unit	: Manager #6 indicated					
	she had told th	e Therapist [#5] who					
	was in the IDT	meeting that Resident					
		screen, and she would					
		hat happened after					
	that.	.,					
	During an inter	view on 12/18/12 at					
	3:13 p.m., the	Director of Health					
	Services (DHS	indicated that OT					
	(occupational t	herapy), PT (physical					
	l ,	ST (speech therapy)					
		d the reacher would not					
		ate intervention, that					
		lated fall and the					
	interventions in						
	appropriate.	h was mara					
							\

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155165	B. WING	G		12/18/	2012
NAME OF B	ADOLUDED OD GLIDDLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C		586 EAS	STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2. Record revi	ew for Resident #31					
	was done on 1	2/17/12 at 4:10 p.m.					
	She was admit	ted on 2/28/2007					
	Diagnoses inc	luded but were not					
	limited to: Oste	oarthrosis, Dementia					
	with depression	n and behaviors,					
	•	r, difficulty walking,					
		vulsions, aphasia,					
		iety, depressive					
		ng loss, high blood					
		estive heart failure,					
		nyroidism, ischemic					
	heart disease.	Tyroldisiri, iscriciffic					
	neart disease.						
	Decident #31 k	nad a fall on 12/6/12					
	and on 12/7/12	•					
		ad not been updated					
		1/4/11. After 2 falls					
		new interventions					
		re to prevent further					
	falls.						
		D : 1 : 1 (10.4)					
		Resident #31's room					
		3:10 p.m., her dresser					
	_	ne foot of her bed with					
	a TV sitting on	top of it. There were					
	electrical wires	(cords) running from					
	the wall to the	things on the dresser.					
	The resident w	as sitting on her bed					
	on the side clo	sest to the outside wall.					
	To get out from	n that side of the bed,					
	_	to walk over the cords					
		erself over the bed.					
		nto the room to assist					
		She indicated she did					
	1 tooldont #01.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155165	B. WIN			12/18/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	₹		586 EAS	STERN BLVD		
RIVERVI	EW VILLAGE			CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		ure why the room was					
		unless it was so she					
	could read the captions on the TV since she can't hear very well.						
	letemie	I DN 44 on 40/47/40 of					
	Interview with LPN #4 on 12/17/12 at						
		indicated the dresser					
		way since she started					
		facility. She thought it					
	•	from the wall so the					
	resident could read the screen. "She sits on her bed and moves from side						
	to side."						
	Interview with	the Maintenance					
		12/17/12 at 4:03 p.m.,					
		ey would mount her TV					
		d move the dresser					
		it the fall hazard.					
	back to preven	it the fall hazard.					
	A policy and p	rocedure for a "Fall					
		Program", with a					
	_	f 6/2012, indicated					
		e policy of American					
	,	unities to ensure					
		ling within the facility					
		naximum physical					
		ough the establishment					
	_	vironmental, and					
		juidelines to prevent					
		o falls. Procedure4.					
		I be initiated as soon as					
		as been assessed and					
		report must be					
		all in order to identify					
	l combiered in it	an in Order to Identity					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165		A. BUILDING B. WING	00	COMPLETED 12/18/2012			
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 586 EASTERN BLVD CLARKSVILLE, IN 47129					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	possible root causes of the fall and provide immediate interventions. An entry will be completed in the EMR (Electronic Medical Record) addressing the fall, any injuries, physician and family notification, and interventions initiated. 5. All falls will be discussed by the interdisciplinary team the next business day morning after the day of the fall to determine other possible interventions to prevent future fallsThe care plan will be reviewed and updated, as necessary." 3.1-45(a)(1) 3.1-45(a)(2)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155165	B. WING			12/18/	2012
NAME OF E	PROVIDER OR SUPPLIE	D	<u>' </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLITEIE	N.		586 EAS	STERN BLVD		
RIVERVI	EW VILLAGE			CLARKS	SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0329 SS=D	UNNECESSARY Each resident's a from unnecessal drug is any drug dose (including dexcessive durati monitoring; or w for its use; or inconsequences with should be reducted to the should be reducted to th	drug regimen must be free ry drugs. An unnecessary when used in excessive duplicate therapy); or for on; or without adequate indications the presence of adverse which indicate the dose ed or discontinued; or any the reasons above. prehensive assessment of a dility must ensure that ave not used antipsychotic wen these drugs unless ug therapy is necessary to ondition as diagnosed and he clinical record; and se antipsychotic drugs dose reductions, and rentions, unless clinically in an effort to discontinue ord review and facility failed to ensure as drug regimen was essary drugs in that 1 to attempted dose Remeron and Zolpidem. If of 10 residents nnecessary Resident #113)	F0329)	F329 States that each residen drug regimen must be free frounnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); of or excessive duration; or withous dequate monitoring; or withous dequate indications for its use or in the presence of adverse consequences which indicate dose should be reduced or discontinued; or any combinations of the reasons above.Based on a	or out ut e;	01/19/2013
					comprehensive assessment of	fa	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIVI	a. Building 00		COMPLETED	
		155165	A. BUII B. WIN			12/18/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			STERN BLVD		
DI\/ED\/I	EW VILLAGE				SVILLE, IN 47129		
	EW VILLAGE			CLARK			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		s's record was reviewed			resident, the facility must ensu		
	on 12/17/12 at	: 10:25 a.m. The record			that residents who have not us		
	indicated Resi	dent #113 was			antipsychotic drugs are not given these drugs unless antipsychological antipsycholog		
	admitted with	diagnoses that			drug therapy is necessary to t		
	included, but w	vere not limited to,			a specific condition as diagnos		
	· ·	difficulty speaking,			and documented in the clinica		
	•	Ider dysfunction,			record; and residents who use	.	
		iculty swallowing,			antipsychotic drugs receive		
	-	•			gradual dose reductions, and		
		ess, cerebral artery			behavioral interventions, unles		
		infarction, high blood			clinically contraindicated, in ar	ו	
		ressive disorder, and			effort to discontinue these drugs. The facility will ensure to	hie	
	vascular deme	entia.			requirement is met through the		
					following corrective measures		
	Physician's red	capitulation orders			Resident #113 has been		
	dated 12/1/12	through 12/31/12			reviewed by the IDR team and	t	
		rder for Mirtazapine			physician notified of request. 2	2.	
		nt) 15 milligrams (mg)			All residents who utilize		
		y bedtime, with a start			anti-psychotropic medications		
	1 -	11, and an order for			be audited, by DNS or designed to answer that prepar CDR's h		
					to ensure that proper GDR's heen initiated. 3. GDR tracket		
		g by mouth every			(see Attachment F329-3) will be		
	peatime, with a	a start date of 12/01/12.			completed by Social Services		
					Director or designee, to ensur	e	
		ctions could be located			GDR assessments are comple		
	in the resident	's record for the			and GDR requests from the		
	Mirtazapine or	the Zolpidem.			physician are timely. The IDT	.	
					team will review the GDR trac	ker	
	During an inte	rview on 12/17/12 at			monthly in the Behavior meeting. Nursing and Social		
		N #1 indicated she			Services staff will be in-service	_{ed}	
	I	where there had been a			on or before January 17th 201		
		ne Mirtazapine or			by the DNS and Staff	<i>'</i>	
		didn't know why the			Development Coordinator, (se	e	
		-			Attachment A and Attachment		
	physician had	not done one.			F329-1) on the ASC Psychotro	opic	
	A				Medication Management		
		rocedure for "ASC			Program. 4. The DNS or		
	Psychotropic N	Medication			designee will utilize the		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155165			LDING	NSTRUCTION 00	(X3) DATE S COMPL 12/18 /	ETED	
	ROVIDER OR SUPPLIER		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE STERN BLVD SVILLE, IN 47129		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Management P was provided b Employee #7 o p.m. The policy limited to, "Policy American Senicy ensure that a real medication region the resident's hymental, physical	ratement of deficiencies cy must be preceded by full LSC IDENTIFYING INFORMATION) rogram" with no date, y Medical Records n 12/18/12 at 3:00 y included, but was not cy: It is the policy of or Communities to esident's psychotropic imen helps promote ighest practicable al and psychosocial		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) Continuous Quality Improveme Unnecessary Medication tool (Attachment F329-2) to ensure GDR's are recommended, who appropriate, weekly for 4 week then monthly for 6 months, the quarterly thereafter. These au will be reviewed during the facility's quarterly CQI meeting and the plan of action adjusted accordingly. If a threshold of S is not met, the plan of action w	ent see en (S, en dits dits dis	(X5) COMPLETION DATE
	managed in coattending physifacility staff to it interventions, a reductions a appropriate facility will initial Gradual Dose Interventions of the following so drugc. For resedative/hypnomust be initiate guidelines: -For resident remain hypnotic, the factor resident will contraindicate of For resident will medications a per the follow (solution) and per the fol	ucility should attempt a unless clinically by the physician. d. no use antidepressant GDR must be initiated sic) guidelines::			be adjusted accordingly by the CQI committee. 5. The above corrective measures will be completed on or before Janua 17 th , 2013.	•	

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PRINTED: 01/22/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155165	A. BUILDING B. WING	00	COMPI 12/18	
	PROVIDER OR SUPPLIER EW VILLAGE	586 EA	ADDRESS, CITY, STATE, ZIP C STERN BLVD SVILLE, IN 47129	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	quarters with at least one month in between attempts, unless clinically contraindicated by the physician. -After the first year, a GDR must be attempted annually unless clinically contraindicated by the physician" 3.1-48(a)(2)				

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